CHIEF COMPLAINT INTAKE SHEET

NAME:____**TODAY'S DATE:**_____________ **BIRTHDATE**____________

PRIMARY CARE PHYSICIAN:__________________________ **REFERRED BY:**________________________________

REASON FOR TODAY'S VISIT/CHIEF COMPLAINT(S):____

BODY PART ___________________________ **RIGHT or LEFT (Circle One)**

DATE OF ONSET/INJURY: ____________________ **EXPLAIN HOW THE PAIN/INJURY STARTED BELOW:**

____

WHAT SYMPTOMS ARE YOU EXPERIENCING? (Circle all that apply)

STABBING PAIN	TENDERNESS	TWINGING	SORENESS	ACHING	BRUISING
CONSTANT PAIN	REDNESS	INSTABILITY	BUCKLING	GIVING WAY	SHOOTING PAIN
INTERMITTENT PAIN	POPPING	CLICKING	NUMBNESS	TINGLING	KNOT OR CYST
PAIN INCREASES AT NIGHT		GRINDING	LOCKING	THROBBING	LOSS OF MOTION
PAIN INCREASES WITH ACTIVITY		SWELLING	WEAKNESS	STIFFNESS	CATCHING
PAIN INCREASES W/WEIGHT BEARING		RADIATING PAIN UP/DOWN		TIGHTNESS	SHARP PAIN

PLEASE MARK ALL CONSERVATIVE TREATMENT YOU HAVE TRIED AND IF YOU NOTICED ANY IMPROVEMENT:

TRIED:	**IMPROVEMENT?**		**TRIED:**	**IMPROVEMENT?**	
____ICE	☐ YES	☐ NO	____SPLINTING/BRACING	☐ YES	☐ NO
____HEAT	☐ YES	☐ NO	____STRETCHING	☐ YES	☐ NO
____REST	☐ YES	☐ NO	____MASSAGE	☐ YES	☐ NO
____SITTING	☐ YES	☐ NO	____NSAIDS (IBUPROFEN)	☐ YES	☐ NO
____LAYING	☐ YES	☐ NO	____TYLENOL	☐ YES	☐ NO
____WALKING	☐ YES	☐ NO	____PARTIAL WEIGHT BEARING	☐ YES	☐ NO
____INJECTIONS	☐ YES	☐ NO	____PHYSICAL THERAPY	☐ YES	☐ NO
____ELEVATION	☐ YES	☐ NO	____OTHER____________________	☐ YES	☐ NO

HAVE YOU BEEN TREATED BY ANOTHER PHYSCIAN OR FACILITY FOR THIS PROBLEM? ___YES or ___NO
IF SO, PLEASE LIST PROVIDER(S) AND TREATMENT(S): ____

____

WERE X-RAYS AND/OR MRI OBTAINED? __YES or __NO **IF SO, WHEN AND WHERE:**___________________________
WAS SURGERY PERFORMED? __YES or __NO **IF SO, WHEN AND WHERE:**____________________________________

CIRCLE THE NUMBER ON THE LINE BELOW THAT REPRESENTS YOUR PAIN <u>RIGHT NOW</u>.

0 1 2 3 4 5 6 7 8 9 10

No pain **Moderate** **Severe** **Excruciating**

<u>INDICATE ON THE DIAGRAM</u>

<u>WHERE YOUR PAIN IS LOCATED.</u>

IS THIS INJURY/CONDITION WORK RELATED? ___YES or ___NO
IS THIS INJURY/CONDITION IN RELATION TO AN AUTO ACCIDENT OR 3RD PARTY LIABILITY? ___YES or ___NO

PERSONAL MEDICAL HISTORY

NAME:____**TODAY'S DATE:**_____________ **BIRTHDATE**____________

HEIGHT:____________**WEIGHT:**___________ **RIGHT or LEFT HANDED (circle one)**

LIST ALL PRIOR SURGERIES: **DATE**

____ __________________
____ __________________
____ __________________
____ __________________
____ __________________
____ __________________
____ __________________

LIST ALL ALLERGIES:____

WORK STATUS (circle one): FULLTIME PART TIME RETIRED STUDENT UNEMPLOYED DISABLED

ARE YOU CURRENTLY TAKING COUMADIN, XARELTO, PLAVIX, AGGRENOX, ASPIRIN, ELIQUIS OR LOVENOX?
___YES or ___NO

ARE YOU CURRENTLY UNDER THE CARE OF A CARDIOLOGIST? ___YES or ___NO

IF YES, WHO IS YOUR CARDIOLOGIST?_______________________________ **DATE OF LAST APPT:**_____________

DO YOU HAVE A PACEMAKER OR ANY METAL IN YOUR BODY? YES OR NO **IF SO, LIST:**_________________________

ARE YOU CLAUSTROPHOBIC? ___YES or ___NO

DO YOU USE TOBACCO PRODUCTS? ___YES or ___NO **IF SO, WHAT KIND?** ____________________________
HOW MANY YEARS? _______________________ **HOW MUCH?** ___________________________________

DO YOU DRINK ALCOHOL? ___YES OR ___NO **IF SO, HOW MUCH?**_____________________________________

MEDICAL HISTORY (*PLEASE CHECK ALL THAT APPLY **CURRENTLY OR IN THE PAST*)**

___ANXIETY	___DVT	___HIATAL HERNIA	___PULMONARY EMBOLISM
___ARTHRITIS	___EPILEPSY	___HIGH BLOOD PRESSURE	___REFLUX
___ASTHMA	___FRACTURE	___HIGH CHOLESTEROL	___RHEUMATIC FEVER
___BACKACHES	___GERD	___INFECTIOUS DISEASE	___SEIZURE DISORDER
___BLOOD DISORDER	___GI DISEASE	___KIDNEY DISEASE	___SHORT OF BREATH
___BLOOD IN STOOL	___GLAUCOMA	___LIVER DISEASE	___SKIN RASH
___CANCER	___GOUT	___MENTAL DISORDER	___STRESS
___CLAUSTROPHOBIA	___HEAD INJURY	___MIGRAINES	___STROKE
___COPD	___HEART ATTACK	___MITRAL VALVE PROLAPSE	___TB
___DEPRESSION	___HEART DISEASE	___PACEMAKER	___THYROID DISEASE
___DIABETES	___HEPATITIS	___PROSTATE DISEASE	___ULCERS
___OTHER____			___UTI

DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE A HISTORY OF: (circle all that apply)

HEART DISEASE DIABETES TB CANCER HIGH BLOOD PRESSURE STROKE ASTHMA SEIZURES
BLEEDING DISORDER THYROID DISEASE KIDNEY DISEASE MENTAL ILLNESS

Please **Mark Yes or No to each item** to indicate which of the following symptoms you are **currently experiencing:**

MUSCULOSKELETAL	YES	NO
Joint Stiffness		
Joint Pain		
Osteoporosis		
Joint Swelling		
Back Pain		
Gout		
Rheumatoid Arthritis		
Limb Swelling		
Ankle Swelling		
Extremity Pain		

GASTROINTESTINAL	YES	NO
Heartburn		
Gastric Ulcer		
Nausea		
Vomiting		
Blood in stool		
Liver, stomach or bowel disorder **(circle one)**		
Hepatitis		

ENDOCRINE	YES	NO
Excessive Thirst		
Excessive Urination		
Temp Intolerance		
Thyroid Disorder		
Diabetes Mellitus		

CONSTITUTIONAL	YES	NO
Weight Loss____lbs		
Fever		
Decreased Appetite		

EARS, NOSE, THROAT	YES	NO
Loss of Hearing		
Hoarseness		

EYES	YES	NO
Blurry Vision		
Double Vision		
Visual Impairment		

CARDIOVASCULAR	YES	NO
Chest Pain		
Palpitations		
Heart Disease		
Hypertension		

RESPIRATORY	YES	NO
Chronic Cough		
Shortness of Breath		
Wheezing		

GENITOURINARY	YES	NO
Painful Urination		
Blood in Urine		
Renal Disorder		

INTEGUMENTARY	YES	NO
Skin Rash		
Skin Lesions		
Skin Lump		
Psoriasis		
Skin Wound		

NEUROLOGICAL	YES	NO
Headaches		
Dizziness		
Seizures		
Dementia		
Numbness/Tingling		

PSYCHOSOCIAL	YES	NO
Depression		
Alcohol Use		
Drug Use		
Sleep Disturbances		

HEMATOLOGIC/LYMPHATIC	YES	NO
Easy Bleeding		
Easy Bruising		
Anemia		
HIV/AIDS		

NAME: ________________________________ **D.O.B:** ___/___/___ **ACCT#:** __________

DATE: ____________

Name: ______________________________ Date of Birth: _______________ ACCT #: ___________

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	**Dosage** *Example: 10.5 mg*	**How Often do you take the Medication?** *Once daily, every 4 hours, every 12 hours, etc.*	**How do you take?** *By mouth, apply to skin, inhale, under tongue, injection, etc*	**Type:** *Tablet, Capsule, patch, drops, ointment, spray, liquid, etc.*	

DATE: _______________ Patient initials: _________